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MEDICAID ENCOUNTER DATA DRIVEN IMPROVEMENT CORE MEASURE SET

AUTOMATED RAPID-CYCLE PERFORMANCE MEASURES FOR THE MEDICAID AND BADGERCARE HMO PROGRAMS

PERFORMANCE MEASURES AND TECHNICAL SPECIFICATIONS

STATE OF WISCONSIN
DEPARTMENT OF HEALTH AND FAMILY SERVICES
DIVISION OF HEALTH CARE FINANCING
BUREAU OF MANAGED HEALTH CARE PROGRAMS

APRIL 2004

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MEDICAID ENCOUNTER DATA DRIVEN IMPROVEMENT CORE MEASURE SET

PERFORMANCE MEASURES AND TECHNICAL SPECIFICATIONS

APPLICABLE TO CALCULATION OF HMO PERFORMANCE RATES BASED ON 2003 DATA.

STATE OF WISCONSIN

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9/13/04	15 16	HealthCheck	Clarify numerator to state "seven or more" exams. Clarify denominator spec to state "HealthCheck" vs. "non-HealthCheck."
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Introduction

Automated quality performance measurement is the goal of nearly all health care delivery systems, yet few, if any large health care delivery systems have attained it. Typically, a system of quality performance measures are thought of as "automated" when they have several characteristics, such as:

- All or most of the data used for performance measurement is generated routinely from normal operations, such as encounter data, not as the result of specialized or separate operations.
- All or most of the data used for performance measurement is available in electronic form and manual medical record review or other labor-intensive operations are not required to extract data separately from paper formats.
- Data is available on an on-going basis as part of a regular electronic data stream, not only as the result of annual data acquisition efforts.
- Performance measures can be calculated at various points in time from the continuous data stream allowing performance measure cycle times to be less than the typical calendar-year cycle times now in use. In addition, an automated system allows time-specific measurement (for example, summer or winter-months only) and measurement periods for specific purposes such as 18 month measure look-back periods, if necessary.
- Electronic data streams can be merged seamlessly with the encounter data stream to improve data accuracy and completeness. For example, electronic data from the Wisconsin Immunization Registry merged with HMO encounter data for a highly accurate childhood immunization delivery rate.

These characteristics have been achieved in the MEDDIC-MS 2004 HMO performance measures described in this manual. This allows performance measurement to be fast, flexible and completed at the lowest possible cost.

Development of the MEDDIC-MS performance measure system began in January 2001. The design has been influenced by a wide variety of stakeholders with updates and revisions occurring up to the publication of the implementation specifications in January 2003. This manual includes all revisions adopted since January 2003.

The first comprehensive set of MEDDIC-MS performance measure results were published in February, 2004 in the MEDDIC-MS 2002 Data Book. The report consists of three volumes. Volume 1 contains program-wide aggregate performance data, Volume 2 presents data specific to the Medicaid program and BadgerCare program and Volume 3 presents HMO-specific performance data on each measure. The MEDDIC-MS 2002 Data Book may be viewed on-line at: http://www.dhfs.state.wi.us/medicaid7/index.htm

The MEDDIC-MS performance measures have been evaluated by the Agency for Healthcare Research and Quality (AHRQ) and accepted for inclusion in the National Quality Measures Clearinghouse (NQMC®). To view the measure summaries on the

NQMC, go to: http://www.qualitymeasures.ahrq.gov/resources/measureindex.aspx and scroll down to "State of Wisconsin."

For further information on the MEDDIC-MS 2004 performance measures contact:

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Notes on MEDDIC-MS 2004 measure calculations:

Measure end date: This is the last date by which measured services can be rendered to be included in the measure numerator. This is the date from which the *look-back period* begins. Typically, the *measure end date* is December 31 if a calendar year is to be measured, but it may be any date specified by the Chief Medical Officer according to program needs. This criterion will be specified in the measure calculation directive.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.* This criterion will be specified in the measure calculation directive.

Measure look-back period*:* Typically, this is 365 days immediately prior to the *measure end date*. The measure look-back period may vary as specified by the Chief Medical Officer according to program needs. This criterion will be specified in the measure calculation directive.

Unduplicated enrollees*:* Denominators for all measures should included un-duplicated enrollees only, unless otherwise specified.

Denominators*:* Report three denominators for all measures based on MedStat code: 1) AFDC/TANF Medicaid enrollees; 2) BadgerCare enrollees; and 3) AFDC/TANF Medicaid enrollees and BadgerCare enrollees combined. Do NOT include any SSI eligibles (iCare) in any of these measures; MEDDIC-MS SSI technical specifications apply to that population.

Very small denominator: When an HMO's denominator for a measure is <30 enrollees, the measure will not be reported for that HMO, however, the data is available to the HMO upon request. If the denominator for the measure is <30 for more than half the participating HMOs, the rate for the measure will be calculated and reported in the aggregate as a program-wide indicator.

Numerators: Include denied encounter records in calculations.

Comprehensive reporting: All measures are to be reported as follows:

Volume 1: Aggregate program-wide results, all HMOs combined, Medicaid (AFDC/TANF) and BadgerCare (SCHIP) MedStat codes combined.

Volume 2: Program-specific results, all HMOs combined Medicaid (AFDC/TANF) and BadgerCare (SCHIP) MedStat codes reported separately.

Volume 3: Medicaid (AFDC/TANF) and BadgerCare (SCHIP) MedStat codes combined but individual HMO-specific results reported for each measure. For measures with multiple age cohorts, report percentage for all age cohorts combined on each measure. SSI (supplemental security income) managed care program reporting is done separately using MEDDIC-MS SSI and no enrollees in this population are to be included in MEDDIC-MS reporting.

1. Ambulatory diabetes care by age cohort

Rationale: This targeted performance improvement measure is designed to measure and improve performance of outpatient management services for people with Type I or Type 2 diabetes. Hospital discharge data analysis has shown this measure to be of high clinical importance to enrollees in both Medicaid (AFDC/HS) and BadgerCare.

Two important diabetes management tests are monitored in the MEDDIC-MS measure system.

One test is the hemoglobin A1c (HbA1c), which is a blood test that indicates the level of blood sugar control over time. The other test is the lipid profile, which is a blood test that monitors the levels of "fats" (lipids) in the blood stream. Though these tests do not allow definitive assessment of quality of life for diabetic individuals nor of total quality of care for diabetes, they do allow assessment of key indicators of diabetic management.

CY 2005 Performance Goals (services delivered in CY 2004): To be determined.

Denominator:

Age cohorts: Medicaid/BadgerCare enrollees age birth-17[1] and 18-75 years as of the measure end date. The first age cohort begins at birth and ends on the last day of the seventeenth year. The second age cohort begins on the eighteenth birthday and ends on the 75th birthday. Birth to 17 age cohort is to be reported in aggregate only and not subject to performance goals.

Enrollment criteria: Must be continuously enrolled with the same HMO for at least 304 days immediately prior to the *measure end date* with no more than one gap in enrollment of not more than 45 days. The enrollee must have a total of not less than 259 enrolled days in the *look-back period*.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator. This is the date from which the *look-back period* begins.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.*

Measure look-back period: 12 months (365 days) from the *measure end date*. Services provided prior to enrollment in the HMO are counted in the numerator if identified in DHCF encounter data, including previous HMO encounter data, FFS or other data as available.

Clinical criteria: Enrollees dispensed insulin and/or oral hypoglycemics/ antihyperglycemics, based on appropriate current NDC codes, during the measure look-back period or had at least two encounters with different dates of service in an

[1] *Pediatrics*, 2000; 105: 671-680, ADA Panel Issues Recommendations for Type II Diabetes Testing in Children.

ambulatory setting or non-acute inpatient setting or one encounter in an acute inpatient or emergency room setting during the measure look-back period, with diagnosis of diabetes identified by the following diagnosis codes: *Exclude all enrollees with gestational diabetes, ICD-9-CM 648.8 in the look-back period.*

ICD-9-CM

250.xx, 357.2, 362.0-02, 648.0 or 366.41.

Acute Inpatient /ER Codes

UB-92 revenue codes: 1OX, 11X, 12X, 13X, 14X, 15X, 16X, 20X, 21X, 22X, 45X, 72X, 80X, 981, 987.

CPT: Inpatient-99221-99223, 99231-99233, 99238-99239, 99251-99255, 99261-99263, 99291-99292. ER: 99281-99288. Prolonged physician services: 99356-99357.

Outpatient/Non-Acute Inpatient Codes

UB-92 revenue codes: 49X, 50X, 51X, 52X, 53X, 55X, 56X, 57X, 58X, 59X, 65X, 66X, 76X, 82X, 83X, 84X, 85X, 88X, 92X, 94X, 96X, 972, 973, 974, 975, 976, 977, 978, 979, 982, 983, 984, 985, 986, 988, 989.

CPT: Office, other outpatient: 92002-92014: ophthalmology, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99271-99275. Preventive services: 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99420-99429. Home or prolonged services: 99341-99355. Other evaluation/management, 99499. Nursing facility examinations: 99301-99303. Nursing facility care: 99311-99313. Home or custodial care: 99321-99323, 99331-99333.

Numerators (reported separately):

Age cohort <u>birth to 17 years</u> is always reported in aggregate only and is not reported on an HMO-specific basis.

Hemoglobin A1c: At least one HbAlc test conducted in the measure look-back period. Encounter data will be used to identify services. CPT-4 and CPT 2001 code 83036.

Lipid Profile: At least one LDL test in the lookback period. Encounter data will be used to identify services. CPT-4 code 80061, 83721 or CPT 2001 codes: 83715, 83716, 83718, 83719.

2. Childhood Immunizations

Rationale: The overall objective for the Childhood Immunization Measure is to reach and sustain full immunization of 90 percent of children two years of age (*Healthy People 2010* goal for attainment by 2010). Full immunization as defined by this measure is based on applicable the recommendations of the Centers for Disease Control Advisory Committee on Immunization Practices (CDC-ACIP).

CY 2005 Performance Goal, (for services delivered in CY 2004): To be determined.

Immunization status reporting:

The Department will provide the HMO with a listing of children found to have partial or unacceptable coverage to facilitate HMO outreach for facilitation of improvement in immunization status.

Required vaccines:

Full coverage: 4 DT/DTP/DTaP, 3 Hib, 3 HBV, 3 IPV/OPV, 1VZV, 1 MMR.

Substantial Coverage: 3 DT/DTP/DTaP, 2 Hib, 2 HBV, 3 IPV/OPV, 1 MMR.

NOTE: All-IPV schedule is recommended for routine childhood polio vaccination. Use of OPV is acceptable only in selected circumstances and must conform to CDC-ACIP recommendations January-December 2001. See MMWR, May 19, 2000/49(RR-5); 1-22.

Incomplete coverage: Children not having either of the above combinations of vaccinations. Impact of vaccine shortages will be evaluated based on scope and severity.

The heptavalent pneumococcal conjugate vaccine (7PCV) delivery rate will be measured as individual numerators, one for children receiving 2, 3 and 4 doses in the look-back period. No minimum performance level for delivery is established at this time. CPT 2001 code: 90669, ICD-9-CM: V03.82.

Technical specifications:

Calculation of Measure:
This measure uses current and previous (if applicable) HMO claims/encounter data, FFS MEDS data and DPH vaccination program (WIR) data to determine the percent of children included in the denominator who received the required vaccines. Services provided prior to the enrollment period or by non-network providers are counted in the numerator when identified in HMO encounter data. DHCF will merge data from DPH or other DHFS databases with HMO encounter data to the extent possible for calculation of the numerator.

Denominator:

Age cohorts: Children 23 months to 25 months, 30 days of age at the *measure end date*.

Enrollment criteria: All criteria must be met.

1. Enrolled at birth or within 45 days of birth.
2. Enrolled with the same HMO *a total* of at least 609 days prior to the measure end date. One gap in enrollment of not more than 45 days in the period of enrollment may occur.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator. *Measure data extraction date*: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.* Data extraction will occur subsequent to the completion of the quarterly update of DPH data for the most recent complete quarter that includes services provided up to the *measure end date* .

Look-back period: The entire enrollment period to the first date of enrollment.

Numerator for *Full Coverage*:

Clinical Criteria:

The number of children in the denominator who received all of the following by the measure end date. (NOTE: *Exclude enrollees with documented contraindications ICD-9-CM V64.0. Data on contraindications is found in "Contraindications for Childhood Immunization" Rev.Oct. 2000, Centers for Disease Control and Prevention (CDC).*)

- **Four DTaP, DT, or DTP with different dates of service, or some combination of DTaP, DTP or DTP/DT vaccines adding up to 4 doses.** Applicable codes:

  CPT-4 and CPT 2001: 90700, 90701, 90702, 90703, 90711, 90719, 90720, 90721, 90723

  ICD-9-CM: 99.39, V02.4, 032, 033, 037, 99.36, 99.37, 99.38, 99.39, V06.1, V06.2, V06.3, V06.5.
- **Three polio (IPV/OPV) vaccinations with different dates of service.** Applicable codes:

  CPT-4 and CPT 2001: 90711, 90712, 90713, 90723

  ICD-9-CM: V12.02, V04.0, 045, 99.41, V06.3.

One each of measles, mumps and rubella or one MMR must be delivered unless contraindication is coded.

- **One measles vaccination.** Applicable codes:

  CPT-4 and CPT 2001: 90705, 90707, 90708, 90710

  ICD-9-CM: 055, 99.45
- **One mumps vaccination.** Applicable codes:

  CPT-4 and CPT 2001: 90704, 90707, 90709, 90710

  ICD-9-CM: 072, 99.46
- **One rubella vaccination.** Applicable codes:

  CPT-4 and CPT 2001: 90706, 90707, 90708, 90709, 90710

ICD-9-CM: 056, 99.47, V04.3.

- **One MMR vaccination.** Applicable codes:

  CPT-4 and CPT 2001: 90707, 90710

  ICD-9-CM: 99.48, V06.4
- **One Varicella (VZV) vaccination.** Applicable codes:

  CPT-4 and CPT 2001: 90716 or 90710

  ICD-9-CM: V05.4

  Or documented history of chicken pox, ICD-9-CM: 052.9.
- **Three H influenza type B (Hib) vaccinations.** Applicable codes:

  CPT-4 and CPT 2001: 90645, 90646, 90647, 90648, 90720, 90721, 90737, 90748

ICD-9-CM: 041.5, 038.41, 320.0, 482.2, V03.81.

- **Three Hepatitis B vaccinations.** Applicable codes:

  CPT-4 and CPT 2001: 90723, 90740, 90744, 90747 and 90748

  ICD-9-CM: V02.61, 070.2, 070.3

Numerator for *Substan**tial Coverage***:**

Clinical Criteria:

The number of children in the denominator who received all of the following by the measure end date. (NOTE: *Exclude enrollees with documented contraindications ICD-9-CM V64.0. Data on contraindications is found in "Contraindications for Childhood Immunization" Rev.Oct. 2000, Centers for Disease Control and Prevention (CDC).*)

- **Three DTaP, DT, or DTP with different dates of service, or some combination of DTaP, DTP or DTP/DT vaccines adding up to 3 doses.** Applicable codes:

  CPT-4 and CPT 2001: 90700, 90701, 90702, 90703, 90711, 90719, 90720, 90721, 90723 ICD-9-CM: V02.4, 032, 033, 037, 99.36, 99.37, 99.38, 99.39, V06.1, V06.2, V06.3, V06.5.

- **Three polio (IPV/OPV) vaccinations with different dates of service.** Applicable codes:

  CPT-4 and CPT 2001: 90711, 90712, 90713, 90723

  ICD-9-CM: V04.0, V12.02, 045, 99.41, V06.3.

One each of measles, mumps and rubella or one MMR must be delivered unless contraindication is coded.

- **One measles vaccination.** Applicable codes:

  CPT-4 and CPT 2001: 90705, 90707, 90708, 90710

  ICD-9-CM: 055, 99.45

- **One mumps vaccination.** Applicable codes:

  CPT-4 and CPT 2001: 90704, 90707, 90709, 90710

  ICD-9-CM: 072, 99.46

- **One rubella vaccination.** Applicable codes:

  CPT-4 and CPT 2001: 90706, 90707, 90708, 90709, 90710

  ICD-9-CM: 056, 99.47, V04.3.

- **One MMR vaccination.** Applicable codes:

  CPT-4 and CPT 2001: 90707, 90710

  ICD-9-CM: 99.48, V06.4

- **Two H influenza type B (Hib) vaccinations.** Applicable codes:

  CPT-4 and CPT 2001: 90645, 90646, 90647, 90648, 90720, 90721, 90737, 90748
ICD-9-CM: 041.5, 038.41, 320.0, 482.2, V03.81.

- **Two Hepatitis B vaccinations.** Applicable codes:
  CPT-4 and CPT 2001: 90723, 90740, 90744, 90747 and 90748
  ICD-9-CM: V02.61, 070.2, 070.3

Reported as separate numerators:

- Two heptavalent pneumococcal conjugate vaccinations (7PCV).[2]
- Three heptavalent pneumococcal conjugate vaccinations (7PCV).
- Four heptavalent pneumococcal conjugate vaccinations (7PCV).

Applicable codes: CPT 2001: 90669 ICD-9-CM: V03.82.

Counting Pediarix:
Pediarix® (CPT code = 90723) was approved by the Food and Drug Administration in December 2002. It replaces the *primary* vaccination series for hepatitis B, IPV, and DTaP. Manufacturer's recommendations must be followed if affected series are initiated with other individual vaccines. Pediarix is not to be used as a booster after the initial three dose series. Pediarix does not replace the DTaP booster at 15-18 months nor the IPV booster at 4-6 years of age.

Three doses of Pediarix®, (recommended at 2, 4 and 6 months of age) can be counted in the numerator for the full and substantial immunization status numerators in place of the first three doses of IPV and DTaP. It is not recommended for the first dose of hepatitis B, as the minimum age for administration of the first dose of Pediarix is six weeks. Consequently, one dose of Hep B vaccine should occur soon after birth, usually given in the hospital. Three doses of Pediarix can be given by age six months. If the initial Hep B dose is not detected in encounter data, but three doses of Pediarix are given at approximately 2, 4, and six months, the child is considered to have received the full primary series.

3. EPSDT (HealthCheck) Comprehensive Well-child Examinations

Comprehensive HealthCheck examinations services, birth to age 2 years.

Rationale: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are required under federal law for individuals under age 21 years served in the Medicaid program. In Wisconsin, EPSDT services are referred to as HealthCheck. Delivery of HealthCheck services for children between birth and age two years are a priority in the Medicaid/BadgerCare program because they facilitate the delivery of vital early childhood preventive health services such as required immunizations and lead toxicity screens. In addition, the diagnostic aspects of the HealthCheck examinations facilitate early intervention in potentially serious conditions, thereby improving quality of life and preventing complications.

[2] MEDDIC-MS 2004 will count delivery of Prevnar® at 2, 3 and 4 dose levels as separate numerators due to CDC recommendations made on 3/2/04 due to vaccine shortage. Four doses is considered optimal.

Technical specifications:

Calculation of the measure:

This measure uses current and previous (if applicable) HMO claims/encounter data, FFS MEDS data, and DPH data to determine the percent of children included in the denominator who received the required HealthCheck examinations. Services provided prior to the enrollment period or by non-network providers are counted in the numerator when identified from DPH or other DHFS databases or identified in encounter data.

Denominator 1:

Age cohorts: Enrollees age 20-28 months at the measure end date.

Enrollment criteria: All criteria must be met.

1. Enrolled at birth or within 45 days of birth.
2. Enrolled with the same HMO at least 518 days continuously with not more than one gap in enrollment of up to 45 days from the date of enrollment.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.* If DPH data is to be included in the numerator, data extraction will occur subsequent to the completion of the quarterly update of DPH data for the most recent complete quarter that includes services provided up to the *measure end date*.

Look-back period: The entire enrollment period to the first date of enrollment.

Numerators:

Children in the denominator who receive:

- seven or more comprehensive HealthCheck examinations with different dates of service by the age two years.
- six comprehensive HealthCheck examinations with different dates of service by the age two years.
- five comprehensive HealthCheck examinations with different dates of service by the age two years.

Clinical criteria:

CPT-4 and CPT 2001 codes: 99431, 99432, 99435, 99381-99385 or 99391-99395 or 99201-99205, 99211-99215 **with:** ICD-9-CM code V 20-20.2, and/or V70.0 and/or V70.3-.9.

Denominator 2

Children age 3-20 years

Calculation of the measure:

This measure uses current and previous (if applicable) HMO claims/encounter data, FFS MEDS data and DPH data to determine the percent of children included in the denominator age cohorts who received at least one HealthCheck well-child examination in the look-back period.

Denominator:

Age cohort (as of measure end date)*:*

i. 3-5 years

ii. 6-14 years

iii. 15-20 years.

Enrollment criteria: Must be continuously enrolled with the same HMO for at least 304 days immediately prior to the *measure end date* with no more than one gap in enrollment of not more than 45 days. The enrollee must have a total of not less than 259 enrolled days in the *look-back period*.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.* If DPH service data is to be included in the numerator, data extraction will occur subsequent to the completion of the quarterly update of DPH data for the most recent complete quarter that includes services provided up to the *measure end date*.

Measure look-back period: 24 months (730 days) from the *measure end date*. Services provided prior to enrollment in the HMO, and services provided by non-network provider(s) are counted in the numerator if reported in current or previous HMO encounter data, FFS or DPH data. (Look-back period is 730 days because a visit is not due every year beyond age 5 years).

Numerator:

Children in the denominator for each age cohort who receive:

- At least one EPSDT HealthCheck examination in the *look-back period*.

Clinical criteria:

CPT-4 and CPT 2001 codes: 99381-99385, 99391-99395, 99431, 99432, 99435. Or 99201-99205, 99211-99215 **with:** ICD-9-CM code V 20-20.2, and/or V70.0 and/or V70.3-.9.

4. Blood Lead Toxicity Screening: Age One and Two Years

Rationale:

Blood lead toxicity screening is a federal requirement for all young children in Medicaid. Exposure to and ingestion of environmental lead is known to cause damage to the

neurological systems in humans and is particularly damaging to young children whose bodies are still developing. Blood lead levels as low as 10 µg/dL are associated with harmful effects on children's learning and behavior. Wisconsin Medicaid/BadgerCare lead toxicity screening standards that are consistent with recommendations of the Centers for Disease Control and Prevention (CDC). See the National Guideline Clearinghouse at: http://www.guideline.gov/summary/summary.aspx?ss=15&doc_id=2738&nbr=1964.

According to CDC, screening efforts should be concentrated on the 0-24 months age group because, "…children's blood lead levels increase most rapidly at age 6-12 months and peak at 18-24 months." Also, "In general, screening should focus on children younger than 72 months of age, particularly on children younger than 36 months of age. Young children engage in the most hand-to-mouth activity (and therefore are at highest risk for lead exposure) and have the most rapidly developing nervous systems, making them more vulnerable to the effects of lead."

The *Healthy People 2010* goal related to blood lead toxicity is to "reduce the prevalence of blood lead levels exceeding 10 µg/dL to zero in children aged 1 to 5." Baseline data cited is from the *National Health and Nutritional Examination Survey, 1988-91*, which supports the estimate that more than 1.7 million children aged 1.5 years have blood lead levels of 10 µg/dL or greater.

CY 2005 Performance Goals, (for services provided in CY 2004): To be determined.

Measure Calculation:
This measure uses current and previous (if applicable) HMO claims/encounter data, FFS MEDS data and DPH lead poisoning prevention program data to determine the percent of children who obtain a blood lead test by approximately age one year and two years. Services provided prior to the enrollment period or by non-network providers are counted in the numerator when identified from DPH or other DHFS databases or identified in HMO encounter data and age at date of service is appropriate for the age cohort.

The measure compares the total number of children in the one-year-old denominator to the number of children with lead screens performed where the child was 6 to 16 months of age at date of service. The measure compares the number of children in the two-year-old denominator to the number of children with lead screens performed where the child was 17 to 28 months of age at date of service.

The measure evaluates provision of age-specific services, so the rate is based on *age at the date of service*. The numerator age cohort criteria achieve this and prevent children who have "aged out" of the one-year-old age cohort, but did receive a screening shortly before turning 17 months of age from being excluded from the rate for one-year-olds.

Denominator:
Age cohorts:

One-year-olds: Children 16-18 months of age as of the *measure end date*.

Two-year-olds: Children 28-30 months of age as of the *measure end date*.

Enrollment Criteria: Enrolled in the HMO at the *measure end date* and had at least 304 days continuous enrollment prior to the *measure end date* with no more than one break in enrollment of up to 45 days. There must be at least 259 days of enrollment in the look-back period

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator. This is the date from which the look-back period begins.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.* Data extraction will occur subsequent to the completion of the most recent complete quarterly update of DPH data for the quarter including services up to the *measure end date* .

Measure look-back period:

One-year-old numerator: Count only those tests administered for children age 6 to 16 months at the date of service. Lead screens provided before six months of age are not included in the numerator.

Two-year-old numerator: Count only those tests administered for children age 17 to 28 months at the date of service. Lead screens provided before age 17 months are counted in the one-year-old numerator.

Numerators:

Numerator #1, Age at date of service: 6-16 months:
The number of children in the denominator who had a blood lead screening performed with a date of service between ages 6 and 16 months. Criteria: encounter with CPT-4/CPT 2001 code 83655 or DPH record of a blood lead test. Codes for new screening procedures that are equivalent to the blood lead test will be added to the numerator specification upon approval and included in the calculation of the screening performance rate.

Numerator #2, Age at date of service: 17-28 months:
The number of children in the denominator who had a blood lead screening performed with a date of service between ages 17 and 28 months. Criteria: encounter with CPT-4/CPT 2001 code 83655 or DPH record of a blood lead test. Codes for new screening procedures that are equivalent to the blood lead test will be added to the numerator specification upon approval and included in the calculation of the screening performance rate.

5. Dental Preventive Care, Age 3-21 years and 21+

This measure applies only to HMOs providing dental care as a covered benefit under the Medicaid/BadgerCare contract.

Rationale:

"Although many dental problems can be prevented with regular screening and preventive services, these services are not always available to those children who need them most. In Federal Fiscal Year 1997, only one in five (20 percent) children eligible for dental services under the Medicaid Early and Preventive Screening, Diagnosis and Treatment (EPSDT) program received a preventive dental service."[3]

- In Wisconsin, from 2000 to 2002, the dental preventive services rate showed statistically significant improvement increasing from 16.8 to 26.8 percent for children age 3-21 years and increasing from 10.3 to 15.4 percent for adults 21 years of age and older.

CY 2005 Performance Goals, (for services provided in CY 2004): To be determined.

Technical Specifications:

Dental Services Measure #1:
The percent of Medicaid enrollees age 3 to 20 years of age who have had at least one preventive dental service *look-back period*.

Calculation of the measure #1:
The measure uses HMO enrollee data to identify the denominator and current and previous (if applicable) HMO claims/encounter data, FFS MEDS data to determine the numerator.

Denominator #1:
Age cohorts: Children age 3 to 20 years of age enrolled in the HMO as of the *measure end date*.

Enrollment criteria: Enrolled continuously for 304 days with the same HMO immediately prior to the *measure end date*. No more than one break of up to 45 days in enrollment. Enrollee must have a total of not less than 259 enrolled days in the *look-back period*.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator. This is the date from which the look-back period begins.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.*

Measure look-back period: 12 months (365 days) from the *measure end date*.

Numerator# 1:
Unduplicated enrollees age 3 to 20, who had a dental visit during the *look-back period*. A member is identified as having a dental visit if he or she has had a claim/encounter that

[3] *Child Health USA 2000,* U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau.

includes both a clinical oral evaluation and prophylaxis as defined by the following CDT-2 Current Dental Terminology (CDT) codes.

The CDT codes: 00120 or D0120 Periodic oral evaluation or
00150 or D0150 Comprehensive initial exam
01120 or D1120 Prophylaxis - child, age 3-12
02220 or D2220 Prophylaxis - adult 13-20
01201 or D1201 Topical application of fluoride (including prophylaxis)-child
01205 or D1205 Prophylaxis with fluoride adult, 13-20
01351 or D1351 Sealant

Dental Services Measure #2:
Unduplicated enrollees age 21 and over who have had at least one preventive dental service in the *look-back period*.

Calculation of the measure #2:
The measure uses MCO enrollee data to identify the denominator and current and previous (if applicable) HMO claims/encounter data, FFS MEDS data to determine the numerator.

Denominator #2:
Age cohorts: Enrollees age 21 and over enrolled in the HMO as of the *measure end date*.

Enrollment criteria: Enrolled continuously for 304 days with the same HMO immediately prior to the *measure end date*. No more than one break of up to 45 days in enrollment. Enrollee must have a total of not less than 259 enrolled days in the *look-back period*.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator. This is the date from which the look-back period begins.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.*

Measure look-back period: 12 months (365 days) from the ***measure end date.***

Numerator #2:
Adults age 21 and over, who had a preventive dental visit during the *look-back period*. A member is identified as having a preventive dental visit if he or she had a claim/ encounter that includes both a clinical oral evaluation and prophylaxis as defined by the following CDT-2 Current Dental Terminology (CDT).

The CDT codes: 00120 or D0120 Periodic oral evaluation or
00150 or D0150 Comprehensive initial exam
01110 or D1110 Prophylaxis-adult, age 21+
01205 or D1205 Topical application of fluoride (including prophylaxis)-adult
01351 or D1351 Sealant

6. Post-hospitalization care for mental illness/substance abuse within 7 and 30 days

Rationale: Mental health/substance abuse services are vital to a person's overall health and sense of well-being. Most individuals prefer outpatient services to meet their healthcare needs whenever possible and that is particularly true for mental health needs.

Research supports that there is a causal relationship between early post-discharge follow-up care and lower rates of readmission. One recent study found the relapse rate for individuals seen within 30 days was only 13.5 percent compared to a relapse rate of 25.1 percent when follow-up care was not provided.[4]

CY 2005 Performance Goals (for services provided in CY 2004): To be determined.

Technical specifications:

Calculation of measure:
This measure uses HMO encounter data to identify enrollees discharged with a selected mental health or substance abuse diagnosis to identify those who have received appropriate follow-up care *by a mental health or substance abuse specialist or with a primary care provider, as separate numerators*. Count discharges for enrollees who have been hospitalized with a discharge date occurring during the *look-back period* and a principal ICD-9-CM diagnosis code indicating a mental health disorder or substance abuse specified below. Do not count enrollees discharged from residential care or rehabilitation programs.

Denominator:
Age cohorts: Enrollees age 6-20 years, and 21 years and older at the time of discharge.

Enrollment criteria: Continuously enrolled without breaks for at least 30 days with the same HMO *prior* to the date of discharge and for at least 30 days after discharge.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator. This is the date from which the look-back period begins.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.*

Measure look-back period: 12 months (365 days) from the *measure end date*, but include in the denominator only those discharges occurring within the first 335 days of the look-back period.

Denominator clinical criteria:

Mental health:

[4] *Evaluation and the Health Professions, Special Edition, State Medicaid Quality Programs*, "Outpatient Utilization Patterns and Quality Outcomes after First Acute Episode of Mental Health Hospitalization," Delmarva Foundation, December 2000.

ICD-9-CM diagnosis codes 295.xx, schizophrenic disorders; 296.xx, affective psychosis; 297.x, paranoid states; 298.x, other non-organic psychoses; 299.xx, psychoses with origin specific to childhood; 300.x, neurotic disorders; 301.x, personality disorders; 308.x, acute reaction to stress; 309.xx, adjustment reaction; 311, depressive disorder, NEC; 312.xx, disturbance of conduct, NEC; 313.xx, disturbance of emotions specific to childhood and adolescence; 314.00 - 314.01, attention deficit disorder.

Substance abuse:

ICD-9-CM diagnosis codes 291.0 - 292.9, Alcoholic and drug psychosis; 303.00 - 305.9, Alcohol and drug dependence in conjunction with ICD-9-CM procedure codes 94.61, Alcohol rehabilitation; 94.63, Alcohol rehabilitation and detoxification; 94.64, Drug rehabilitation; 94.66, Drug rehabilitation and detoxification; 94.67, Combined alcohol and drug rehabilitation; 94.69, Combined alcohol and drug rehabilitation and detoxification; or UB-92 revenue codes 944, Drug rehabilitation (inpatient, non-residential setting); or 945, Alcohol rehabilitation (inpatient, non-residential setting).

If a member has more than one discharge during the *look-back period* with a principal diagnosis of one of the selected mental health/substance abuse disorders listed above, those discharges are each included in the denominator. However, if a discharge for one of the selected MH/SA disorders is followed by a readmission or a direct transfer to an acute or non-acute facility for any MH/SA principal diagnosis within the 30-day follow-up period, only the readmission discharge or the discharge from the facility to which the member was transferred should be counted, provided it meets the clinical criteria.

Numerators:
The number of discharges in the denominator that were followed by an ambulatory mental health or substance abuse encounter or day/night treatment within 7 and 30 days of hospital discharge reporting separate rates for each. Count enrollees with an encounter at 7 days only once in the numerator for 30 day follow-up, in addition to those enrollees with no encounter by 7 days but with an encounter by 30 days.

NOTE on HIPAA Procedure Code Modifiers:

Use the following procedure codes with or without HIPAA procedure code modifiers, unless otherwise specified. See table below:

HIPAA Procedure Code Modifiers for Mental Health and Substance Abuse Services	
Modifier	**Description**
HN	Bachelor's degree level
HO	Master's degree level
HP	Doctoral level
UA	Psychiatrist--MD
UB	Advanced Practice Nurse Practitioner
UC	Service provided in home or community setting
U7	Paraprofessional
U8	PA-C (physician assistant)

Numerator#1: Specialist follow-up care clinical criteria:

The follow-up visit must be with a mental health/substance abuse provider and can be for any mental health/substance abuse diagnosis. To identify ambulatory mental health follow-up encounters, use the CPT-4 and CPT 2001 codes listed below or the UB-92 revenue codes: 900 psychiatric/psychological treatments; 901 electroshock treatment; 909 other psychiatric treatment; 910 general psychiatric services; 911 rehabilitation; 912 psychiatric/ psychological partial hospitalization, less intense; 913 psychiatric/ psychological partial hospitalization, intensive; 914 individual therapy; 915 group therapy; 916 family therapy, 961 psychiatric professional service; or 513, clinic-psychiatric.

The following mental health procedure codes are included in this measure: 90801, diagnostic assessment; 90802 interactive psychiatric diagnostic interview; 90804-90809, individual psychotherapy; 90810-90815, interactive' psychotherapy; 90816-90822, individual psychotherapy; 90823-90829, interactive psychotherapy***(exclude services coded 90816-90829 from count in numerator if provided during an acute care inpatient stay or residential care facility. Count in numerator if provided during partial hospitalization only)***; 90804-90809 and 90816-90819 and 90821, 90822); 90845, psychoanalysis; 90847, family psychotherapy; 90849, multifamily group therapy; 90853, group psychotherapy; 90810-90815 and 90823-90829***)***; 90857, interactive group psychotherapy; 90862, pharmacology management; 90870-90871 electro-convulsive therapy; 99201-99205, problem-focused new patient office visit, 99211-09215, problem-focused established patient office visit, 99241-99245, new or established patient problem-focused office consultation, 99341-99345, home visit, 99347-99350, home visit, established patient, 99383-99387 new patient, preventive services with comprehensive exam, age 5 and over; 99393-99397 established patient, preventive services with comprehensive exam, age 5 and over; 99401-99404 individual counseling, preventive medicine, risk reduction.

Substance abuse:

To identify ambulatory substance abuse follow-up encounters, use CPT codes 90857, Interactive group psychotherapy; 90862, Pharmacologic management with no more than minimal medical psychotherapy; 90865, Narcosynthesis for psychiatric diagnostic and therapeutic purposes; 90870 - 90871, Electroconvulsive therapy; 90887, Interpretation of tests or exams; 99201-99205, problem-focused new patient office visit, 99211-09215, problem-focused established patient office visit, 99241-99245, new or established patient problem-focused office consultation, 99341-99345, home visit, 99347-99350, home visit, established patient, 99383-99387 new patient, preventive services with comprehensive exam, age 5 and over; 99393-99397 established patient, preventive services with comprehensive exam, age 5 and over; 99401-99404 individual counseling, preventive medicine, risk reduction.

HCPCS codes W8968 ***or H0022.*** Individual AODA treatment; W8969 ***or H0005.*** Group AODA treatment; W8970, ***or T1006.*** Family AODA treatment; W8972 - W8979 ***or H0022, T1006, H0005.*** Individual/family or group AODA therapy; W8982 ***or H2012HF***, AODA day treatment. Count these codes only if they appear with ICD-9-CM

codes 291.0 - 291.9, (alcoholic psychosis), 303.00 - 305.90 (alcohol dependence syndrome, drug dependence, and nondependent abuse of drugs).

Numerator #2: Primary care provider follow-up clinical criteria:

The same diagnosis codes must be applied as for specialist follow-up care. The same clinical criteria used to identify ambulatory follow-up encounters with a mental health/substance abuse provider, only the services must be provided by a primary care provider. ***Do not count procedures with the following code modifiers for the PCP numerator: HN, HO, or HP.***

Numerator #3: Other or unspecified provider follow-up clinical criteria:

The same diagnosis codes must be applied as for specialist follow-up care. The same clinical criteria used to identify ambulatory follow-up encounters with a mental health/substance abuse provider apply, only the provider is neither a specialist nor a PCP or is unspecified.

Measure provider criteria:
A doctor of medicine (MD) or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board.of Neurology and Psychiatry or, if not certified, has successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice.

An individual who is licensed as a psychologist in his/her state of practice.

An individual who is certified as a clinical social worker by the American Board of Examiners in Clinical Social Work or is listed on the National Association of Social Worker's Clinical Register or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice.

A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist or has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience, and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice.

An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or certified to do so by the state of practice or, if licensure or certification is not required by the state of practice, is eligible for clinical membership in the American Association for Marriage and Family Therapy.

An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and is licensed or certified to do so by the state of practice or, if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board of Certified Counselors (NBCC).

Certified Professional Counselor and State Certified Psychotherapists

Certified Professional Counselor (CPC) must have one of the following degrees, MS, MA, M.ED, MSN, have passed the National Counselor Exam or the Clinical Rehabilitation Counselor Exam and be hold a valid Wisconsin license. A qualified CPC may perform counseling through various means of applying a combination of human development, rehabilitation and either psychosocial or psychotherapeutic principles, procedures or services that integrate a wellness, pathology and multicultural model of human behavior in order to assist an individual, couple, family, group of individuals, organization, institution or community to achieve mental, emotional, physical social, moral, educational, spiritual, vocational or career development and adjustment through the life span of the individual, couple, family, group of individuals, organization, institution or community.
Please see:
http://www.drl.state.wi.us/agencies/drl/Regulation/applicant_information/dod1044.html
Please see: http://www.wisconsin.gov/state/app/license

To be considered a **State Certified Psychotherapist**, the CPC must have completed 3000 hours of supervised experience in a Mental Health Setting after which time they are certified to bill third parties for their services in psychotherapy.

Substance abuse Provider criteria*:* The follow-up visit must be with a mental health or chemical dependency provider, including CADC I, II, or III with appropriate clinical oversight.

Primary care provider criteria: Follow-up care encounters provided by any MD, DO, APN or other provider type that may be selected as a primary care provider by enrollees under the Medicaid/BadgerCare contract may be counted in the numerator for PCP follow-up care (numerator #2).

7. Satisfaction with HMO customer service:

Rationale:

Overall enrollee satisfaction with HMO quality of care, access, service and other key characteristics of the managed health care delivery system was assessed in late 1999 and early 2000 using the Medicaid CAHPS® Enrollee Satisfaction Survey for adults and children. The survey tool included state-specific modifications.

The survey revealed relatively high overall enrollee satisfaction with Wisconsin Medicaid HMOs in general, quality of care, physician care and office staff, and access to care. The domain of HMO customer service was found to have the lowest rate of overall enrollee satisfaction of all the areas surveyed. Only 67.3 percent of respondents said getting the information or assistance they needed when they contacted their HMO customer service department was "not a problem." While this was slightly higher than the national average reported by NCQA in the *State of Managed Care Quality 2000,* the DHCF Quality Management Committee agreed that the results indicated the need for a performance measure and the addition of contract requirements in the area of customer service.

The Medicaid CAHPS® Enrollee satisfaction survey was administered statewide again in 2002. Two HMOs found to be statistically significantly below the state-wide HMO average on the customer service indicator in 1999 improved significantly in 2002. In all, six HMOs had improved ratings on this indicator in 2002.

2004 Performance Goals (for the survey to be administered in 2004): Trend data only.

8. Satisfaction with referral for mental health/substance abuse care.

Rationale:

In order to augment clinical measures of access to mental health and substance abuse care, the MEDDIC-MS system includes a measure of enrollee satisfaction with access to those services that are part of the state's CAHPS® Enrollee Satisfaction Survey.

The survey questions used for this measure in the CAHPS® survey in 1999 and 2002 were somewhat different, but both asked enrollees to rate their satisfaction with access to mental health and substance abuse services. The 1999 question asked enrollees whether they got the MH/SA care they felt they needed and to give a "yes" or "no" response. The 2002 question asked enrollees to rate getting MH/SA care they felt they needed on whether getting that care was "no problem," a "small problem," or a "big problem."

Future CAHPS® satisfaction survey questions on this topic will not be changed from the 2002 survey to allow direct comparison.

Remembering that there was a difference between the questions asked on the two surveys, the rate of satisfaction with access to mental health surveys increased in 2002 from 1999, going from 84 percent to 88.9 percent.

2004 performance goal (the survey will be administered in 2004): Trend data only.

M E D D I C - M S 2 0 0 4

MEDICAID ENCOUNTER DATA DRIVEN IMPROVEMENT CORE MEASURE SET

TECHNICAL SPECIFICATIONS
MONITORING MEASURES

CHRONIC CONDITIONS

1. Asthma care

a. Period prevalence of asthma:

Technical specifications:

Measure is calculated based on current HMO encounter data only.

Denominator

Age cohorts: Birth to age 20 years and over age 21 years.

Enrollment criteria: Must be continuously enrolled with the same HMO for at least 304 days immediately prior to the *measure end date* with no more than one gap in enrollment of not more than 45 days. The enrollee must have a total of not less than 259 enrolled days in the look-back period.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator. This is the date from which the *look-back period* begins.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.*

Measure look-back period: 365 days from the *measure end date*. Services provided prior to enrollment in the HMO are not counted in the numerator.

Numerator #1: Enrollees with a diagnosis of asthma

Clinical Criteria

Enrollees in each age cohort with encounter primary diagnosis codes for asthma. ICD-9-CM 493.x.

b. Asthma inpatient care:

Denominator

Enrollees in numerator #1 above.

Numerator #2

Enrollees in the denominator with at least one inpatient discharge for the asthma diagnoses above.

Query for encounters including an inpatient discharge with a principal diagnosis of asthma, ICD-9 CM 493.x. An inpatient discharge is identified by DRG codes 0096, 0097, or 0098, or by a principal diagnosis of asthma (493.x) paired with one of the following procedure or revenue codes: CPT 99217-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291, or 99292; UB-92 10X-16X, 20X-22X, 76X, or 987.

c. Asthma ED (emergency department) care:

Denominator

Enrollees in numerator #1 above.

Numerator

Enrollees in the denominator with at least one ED encounter for the asthma diagnoses above.

Query for encounters including an emergency department visit with a principal diagnosis of asthma, ICD-9 CM 493.x. An emergency department visit is identified by a principal diagnosis of asthma (493.x) paired with one of the following procedure or revenue codes: CPT 99281-99285 or 99288; UB-92 45X or 981.

WOMEN'S HEALTH

1. Maternity care

a. Deliveries resulting in live births

Technical specifications:

Denominator

Age cohorts:

i. 11 years and under

ii. 12-14 years

iii. 15-20 years

iv. 21-34 years

v. 35-49 years

vi. 50-65 years

Enrollment criteria: Must be enrolled with the HMO as of the delivery date and at least 30 days subsequent to delivery.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator. This is the date from which the *look-back period* begins.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.*

Measure look-back period: 365 days from the *measure end date*. Services provided prior to enrollment in the HMO are not counted in the numerator. Only HMO encounter data is used for the measure.

Denominator clinical criteria: All unduplicated deliveries resulting in live births by age cohort. Applicable codes:

All unduplicated deliveries and subsequent verification of live births by age cohort. Applicable codes for identification of deliveries:

DRG: 370-375, or
ICD-9 CM diagnosis codes: 650, V27.0, V27.2-3, V27.5-6, or
ICD-9 CM diagnosis codes, with a fifth digit of 1 or 2: 640.0x-648.9x, 651.0x-656.3x, 656.5x-676.9x, or
ICD-9 CM procedure codes: 72.0-73.9, 74.0-74.2, 74.4, 74.99, or

CPT-4 procedure codes: 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622.

Applicable codes for exclusion of deliveries resulting in still birth or fetal demise:
ICD-9 CM diagnosis codes: 656.4, V27.1, V27.4, V27.7

NOTE: If any code that could be associated with a live birth occurs more than once for any given unduplicated enrollee, use the earliest occurring date associated with the code as the delivery date.

b. Cesarean sections

Numerator:

Clinical criteria:

Enrollees in the denominator with delivery by Cesarean section.

Applicable codes:

DRG: 370-371, or

ICD-9-CM diagnosis code: 669.7x. Procedure codes: 74.0-74.2, 74.4, and 74.99.

CPT-4/2001: 59510, 59514, 59515, 59618, 59620, 59622, in conjunction with one any of the following ICD-9-CM codes: V27.0, 2, 3, 5, or 6.

c. Deliveries with substance abuse treatment

Clinical criteria:

Enrollees in the denominator who received substance abuse treatment services during the look-back period. Report for delivery occurring in the measure *look-back period* and the substance abuse treatment codes listed below during the *look-back period*. Count only those services provided during the period of enrollment.

Applicable outpatient substance abuse treatment codes:

NOTE on HIPAA Procedure Code Modifiers:

Use the following procedure codes with or without HIPAA procedure code modifiers, unless otherwise specified. See table below:

HIPAA Procedure Code Modifiers for Mental Health and Substance Abuse	
Modifier	**Description**
HN	Bachelor's degree level
HO	Master's degree level
HP	Doctoral level
UA	Psychiatrist--MD
UB	Advanced Practice Nurse Practitioner
UC	Service provided in home or community setting
U7	Paraprofessional
U8	PA-C (physician assistant)

CPT-4/2001 codes: 90804-90815, 90845-90857, 90862-90871, 90875, 90876, 90880, 90887-90889, 90899, 99201-99205, 99211-99215 if they are used in conjunction with ICD-9-CM diagnosis codes: 291-292.9, 303.00-305.93, 965.0x-965.8x, 967.xx, 968.0, 969.xx.

HCPCS codes: W8968 ***or H0022.*** Individual AODA treatment; W8969 ***or H0005.*** Group AODA treatment; W8970, ***or T1006.*** W8972-W8979, ***or H0022.*** Individual/family or group AODA therapy; W8982 ***or H2012HF***, AODA day treatment with ICD-9-CM diagnosis codes: 291-292.9, 303.00-305.93, 965.0x-965.8x, 967.xx, 968.0, 969.xx.

AND/OR

Revenue codes 944 or 945 (outpatient place of service) with ICD-9-CM diagnosis codes: 291-292.9, 303.00-305.93, 965.0x-965.8x, 967.xx, 968.0, 969.xx.

Exclude place of service codes: 21, 31, 32, 51, 52, 54, 56.

Applicable inpatient substance abuse treatment codes:

DRG: 433-437

Or;

ICD-9-CM: 291-292.9, 303.00-305.93, 965.0x, 965.8x, 967.xx, 968.5x, 969.xx.

UB-92 revenue codes: 116, 126, 136, 146, 156.

d. Deliveries with HIV test.

Clinical criteria:

Enrollees in the denominator who received testing for HIV during the *look-back period.*

Applicable codes:

CPT-4/2001: 86689, 86701-86703, 87390, 87391.

e. Prenatal care coordination

Numerator:

Clinical criteria:

Enrollees in the denominator receiving PNCC.

Applicable codes:

HCPCS: H1000 and H1002-H1004.

Breast cancer detection--screening mammography

a. Mammograms provided to women by age cohort.

Technical specifications:

Denominator

Age cohorts: Female enrollees (excluding those with history of bilateral radical mastectomy, CPT-2001: 19180,19200-19220, 19240, or ICD-9-CM: 85.35-85.36, 85.44, 85.46, 85.48)--

i. 40-49 years of age.

ii. 50+ years of age.

Age cohort is determined by enrollee age at the measure end date.

Enrollment criteria:

Must be continuously enrolled with the same HMO for at least 304 days immediately prior to the *measure end date* with no more than one gap in enrollment of not more than 45 days. The enrollee must have a total of not less than 259 enrolled days in the look-back period.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator. This is the date from which the *look-back period* begins.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.*

Measure look-back period: 365 days from the *measure end date*.

Numerator:
Enrollees in the denominator for each age cohort who had at least one mammogram in the measure look-back period based on current and previous (if applicable) HMO claims/encounter data and FFS MEDS data.

Clinical criteria:

CPT-4/2001 codes: 76090-76092 (x-ray mammogram).

ICD-9-CM procedure codes: 87.36, 87.37;

Revenue codes 401 or 403;

Or, revenue codes 320 or 400 in conjunction with ICD-9-CM diagnosis codes 174.xx, 198.81, 217, 233.0, 238.3, 610.0, 610.1-2, 611.72, 793.8, V10.3, V76.1, V76.10-12 and V76.19.

b. Malignancies of the breast detected

The number of enrollees diagnosed with breast malignancy among those screened.

Technical specifications:

Denominator:

Unduplicated enrollees included in the numerator for measure (a) above.

Numerator:

Clinical criteria:

ICD-9-CM diagnosis codes: 174.xx, 198.81, or 233.0. Count malignancies detected on or after the mammogram date of service, but before the measure end date.

2. Cervical cancer detection-screening Pap tests

a. Pap tests provided to women in each age cohort.

Technical specifications:

Denominator

Age cohorts: Female enrollees (exclude enrollees with history of total abdominal or vaginal hysterectomy, ICD-9-CM 68.4, 68.5, 68.51, 68.59, or radical, 68.6,68.7, 68.8, 68.9; or CPT-2001: 58210, 58150, 58152, 58200, 58285)--

i. 18-65 years of age.

Age cohort is determined by enrollee age at the measure end date.

Enrollment criteria:

Must be continuously enrolled with the same HMO for at least 304 days immediately prior to the *measure end date* with no more than one gap in enrollment of not more than 45 days. The enrollee must have a total of not less than 259 enrolled days in the *look-back period*. Exclude from the denominator enrollees with a Pap test encounter as defined in the clinical criteria in the 24 months prior to the *look-back period*, from any source.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator. This is the date from which the *look-back period* begins.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.*

Measure look-back period: 12 months (365 days) from the *measure end date*.

Numerator:
Enrollees in the denominator for each age cohort who had at least one Pap test in the measure look-back period, based on current and previous (if applicable) HMO claims/encounter data and FFS MEDS data.

Clinical criteria:

CPT-4/2001 codes: 88141, 88142-88145, 88147, 88148, 88150, 88152, 88153, 88154, 88155, 88164-88167.

Revenue code 923.

ICD-9-CM diagnosis codes: 795.0. Procedure codes: 91.46, V76.2, V76.47, V67.01.

b. Malignant, pre-malignant lesions of the cervix or uterus or HPV detected

The number of enrollees diagnosed with cervical/uterine malignancy among those screened. Count malignancies detected after the Pap test date of service, but before the measure end date.

Technical specifications:

Denominator:

Enrollees included in the numerator for measure (a) above.

Numerator #1, malignant and pre-malignant lesions:

Clinical criteria:

ICD-9-CM diagnosis codes: 179, 180.x, 182.0-182.8, or 233.1-2.

Numerator #2, Human papillomavirus (HPV) detected:

Clinical criteria:

ICD-9-CM diagnosis codes: 079.4.

Child Health

1. Non-HealthCheck ambulatory and well-child encounters, by age cohort.

Technical Specifications

Calculation of the measure:

This measure uses current and previous (if applicable) HMO claims/encounter data, and FFS MEDS data to determine the percent of children included in the denominator age cohorts who received at least one non-HealthCheck well-child examination.

Denominator:

Age cohorts:

iv. < 1 year

v. 1-2 years

vi. 3-5 years

vii. 6-14 years

viii. 15-20 years.

Age cohort is determined by enrollee age at the measure end date.

Enrollment criteria: Must be continuously enrolled with the same HMO for at least 304 days immediately prior to the *measure end date* with no more than one gap in enrollment of not more than 45 days. The enrollee must have a total of not less than 259 enrolled days in the *look-back period*.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.*

Measure look-back period: 365 days from the *measure end date*.

Numerator: non-HealthCheck ambulatory child care encounters:

Children in each denominator age cohort who received at least one non-HealthCheck well-child examination or at least one non-HealthCheck, non- well-child encounter (i.e., acute illness, non-preventive and not routine physical exam) in the *look-back period*.

Clinical criteria:

CPT-4 and CPT 2001 codes: 99201-99205, 99211-99215, 99241-99245, 99271-99275, 99381-99385, 99391-99395.

MENTAL HEALTH AND/OR SUBSTANCE ABUSE

1. Outpatient mental health and/or substance abuse evaluations

Technical specifications:

Denominator

Age cohorts:

i. 0-18 years

ii. 19+ years

Enrollment criteria: Must be continuously enrolled with the same HMO for at least 304 days immediately prior to the *measure end date* with no more than one gap in enrollment of not more than 45 days. The enrollee must have a total of not less than 259 enrolled days in the *look-back period*.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.*

Measure look-back period: 365 days from the *measure end date*.

Numerators

Numerator #1, MH/AODA outpatient evaluation

Unduplicated enrollees in the denominator age cohorts receiving at least one outpatient mental health or substance abuse evaluation. Include services provided by mental health or substance abuse specialty providers (see definition on page 23), based on current and previous (if applicable) HMO claims/encounter data and FFS MEDS data.

Clinical criteria:

NOTE on HIPAA Procedure Code Modifiers:

Use the following procedure codes with or without HIPAA procedure code modifiers, unless otherwise specified. See table below:

HIPAA Procedure Code Modifiers for Mental Health and Substance Abuse	
Modifier	**Description**
HN	Bachelor's degree level
HO	Master's degree level
HP	Doctoral level
UA	Psychiatrist--MD
UB	Advanced Practice Nurse Practitioner
UC	Service provided in home or community setting
U7	Paraprofessional
U8	PA-C (physician assistant)

CPT-4/2001 codes: 90801, 90802, 96100, 96115, 96117

HCPCS: W8913 ***or H2012***, W8914 ***or H2012,*** W8931-W8933, W8980 ***or H2012,*** W8981, W8987 ***or H0046 or H0047,*** W8989; and/or revenue code 918 in place of service outpatient hospital.

Numerator #2, MH day/outpatient treatment

Enrollees in the denominator age cohorts diagnosed with non-organic, non-substance abuse mental health disorder (use ICD-9-CM diagnosis codes listed on page 26) receiving day/outpatient mental health treatment. Include and report separate rates for services provided by mental health specialists (see definition on page 21) primary care provider (PCPs)/unspecified providers, based on current and previous (if applicable) HMO claims/encounter data and FFS MEDS data.

Clinical criteria:

To identify day/outpatient treatment encounters, use the CPT-4 and CPT 2001 codes listed below or the UB-92 revenue codes: 900 psychiatric/psychological treatments; 901 electroshock treatment; 909 other psychiatric treatment; 910 general psychiatric services; 911 rehabilitation; 912 psychiatric/ psychological partial hospitalization, less intense; 913 psychiatric/ psychological partial hospitalization, intensive; 914 individual therapy; 915 group therapy; 916 family therapy, 961 psychiatric professional service ; or 513, clinic-psychiatric.

The following mental health procedure codes are included in this measure: 90801 diagnostic assessment; 90802 interactive psychiatric diagnostic interview; 90804-90809, individual psychotherapy; 90810-90815, interactive' psychotherapy; 90816-90822, individual psychotherapy; 90823-90829, interactive psychotherapy***(exclude services coded 90816-90829 from count in numerator if provided during an acute care inpatient stay or residential care facility. Count in numerator if provided during partial hospitalization only)***;. 90845 and 90804-90809 and 90816-90819 and 90821, 90822; 90845, psychoanalysis; 90847, family psychotherapy; 90849, multifamily group therapy; 90853, group psychotherapy; 90810-90815 and 90823-90829; 90857, interactive group psychotherapy; 90862, pharmacology management; 90870-90871 electro-convulsive therapy; 99201-99205, problem-focused new patient office visit, 99211-09215, problem-focused established patient office visit, 99241-99245, new or established patient problem-focused office consultation, 99341-99345, home visit, 99347-99350, home visit, established patient, 99383-99387 new patient, preventive services with comprehensive exam, age 5 and over; 99393-99397 established patient, preventive services with comprehensive exam, age 5 and over; 99401-99404 individual counseling, preventive medicine, risk reduction.

Numerator #3, Substance abuse day/outpatient treatment.

Unduplicated enrollees in the denominator age cohorts with substance abuse diagnosis receiving day/outpatient substance abuse treatment (use ICD-9-CM diagnosis codes listed on page 26). Include and report rates separately services provided by substance abuse specialists, primary care provider (PCPs)/unspecified providers.

Clinical criteria:

To identify day/outpatient treatment encounters, use CPT codes 90857, Interactive group psychotherapy; 90862, Pharmacologic management with no more than minimal medical psychotherapy; 90865, Narcosynthesis for psychiatric diagnostic and therapeutic purposes; 90870 - 90871, Electroconvulsive therapy; 90887, Interpretation of tests or exams; 99201-99205, problem-focused new patient office visit, 99211-09215, problem-focused established patient office visit, 99241-99245, new or established patient problem-focused office consultation, 99341-99345, home visit, 99347-99350, home visit, established patient, 99383-99387 new patient, preventive services with comprehensive exam, age 5 and over; 99393-99397 established patient, preventive services with comprehensive exam, age 5 and over; 99401-99404 individual counseling, preventive medicine, risk reduction.

HCPCS codes W8968 ***or H0022.*** Individual AODA treatment; W8969 ***or H0005.*** Group AODA treatment; W8970, ***or T1006.*** Family AODA treatment; W8972 - W8979 ***or H0022, T1006, H0005.*** Individual/family or group AODA therapy; W8982 ***or H2012HF***, AODA day treatment. Count these codes only if they appear with ICD-9-CM codes 291.0 - 291.9, (alcoholic psychosis), 303.00 - 305.90 (alcohol dependence syndrome, drug dependence, and nondependent abuse of drugs).

GENERAL AND SPECIALTY CARE

Technical specifications:

Denominator

Age cohorts:

i. <1 year

ii. 1-2 years

iii. 3-5 years

iv. 6-14 years

v. 15-20 years

vi. 21+ years

Enrollment criteria: Must be continuously enrolled with the same HMO for at least 304 days immediately prior to the *measure end date* with no more than one gap in enrollment of not more than 45 days. The enrollee must have a total of not less than 259 enrolled days in the *look-back period*.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.*

Measure look-back period: 365 days from the *measure end date*. Services provided prior to enrollment in the HMO are not counted in the numerator.

Numerator #1, Emergency department (ED) visits without admission to inpatient care, by age cohort.

Clinical Criteria:

Enrollees in each denominator age cohort receiving at least one encounter of care in an emergency department of an acute care provider facility without subsequent admission to an inpatient care facility as a direct result of the ED visit in the *measure look-back period*.

CPT-4/2001 codes: 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239 and 99291, 99292, or 99281-99285 with HCFA 1500 place of service code 23.

or

UB-92 revenue codes: 450, 451, 452, 456, 459 with "type of bill" code 13x (hospital outpatient) 43x (emergency room).

Numerator #2, Primary care encounters.

Clinical Criteria:

Enrollees having one or more primary care encounters and enrollees having at least one encounter in the measure *look-back period*. Also calculate the total of all primary care encounters for each denominator age cohort. Primary care encounters are ambulatory care encounters for any purpose provided by any provider type defined in the HMO contract that the enrollee may select for primary care.

CPT-4/2001 codes: 99201-99215, 99381-99387, 99391-99397, 99401-99404 preventive medicine, individual counseling, 99420 health risk assessment, 99429 unlisted preventive health services**.**

Numerator #3, Vision care encounters.

Clinical Criteria:

Enrollees in each denominator age cohort having one or more vision care encounters and at least one vision care encounter in the measure *look-back period*. Count only encounters with an ophthalmologist or optometrist provider type.

CPT-4/2001 codes: ***92012, 92014,*** 99201-99205, 99211-99215, 92499 or HCPCS codes W8004 or W8009.

Numerator #4, Audiology encounters.

Clinical Criteria:

Enrollees in each denominator age cohort having one or more audiology encounters and at least one audiology encounter in the measure *look-back period*. Count only encounters with an audiology specialist provider.

CPT-4/2001 codes: 92506-92508, 92541-92547, 92551-92569, 92571-92579, 92582-92584, 92590-92599.

Numerator #5, Dental encounters.

Clinical Criteria:

Enrollees in each denominator age cohort having one or more dental care encounters and at least one dental encounter in the measure *look-back period*. Count only encounters with a dentist (DDS or DDM). **NOTE: Calculate ONLY for those HMOs that offer dental care.**

CPT-4/2001 codes: 70300, 70310, 70320, 70355; or

ICD-9-CM procedure codes: 23.xx, 24.xx, 87.11, 87.12, 89.31, 93.55, 97.33-97.36, 97.22, 97.97; or

CDT-2 codes: 00120, 00140, 00150, 00160, 00210-00340, 00415-00999, 01110-11550, 02220 or

HCPCS codes: D0120, D0150, D0160, D0210, D0470, D1110-D1205, D1351.

INPATIENT CARE

These monitoring measures track total discharges for selected inpatient services in the *look-back period*. Report denominator size, numerator/denominator percentage, total discharges, total inpatient days and average length of stay for each numerator, by applicable age cohort by HMO and as an aggregate total.

Technical specifications:

Denominator

Age cohorts:

i. <1 year

ii. 1-2 years

iii. 3-5 years

iv. 6-14 years

v. 15-20 years

vi. 21+ years

Enrollment criteria: Must be continuously enrolled with the same HMO for at least 304 days immediately prior to the *measure end date* with no more than one gap in enrollment of not more than 45 days. The enrollee must have a total of not less than 259 enrolled days in the *look-back period*.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.*

Measure look-back period: 365 days from the *measure end date*. Services provided prior to enrollment in the HMO are not counted in the numerator.

Numerator #1, Inpatient maternity care.

Clinical criteria:

Include all inpatient hospitalizations for maternity-related diagnoses. Diagnosis codes for maternity discharges:

DRG: 370-384.

ICD-9-CM: 630-676.94 and V24.x.

Report the following inpatient diagnoses codes: V22.x, V23.x, V27.x, and V61.5-V61.7, where "x" equals any fourth digit.

UB-92 revenue codes: 112, 122, 132, 142, 152.

Numerator #2, Neonatal care.

Clinical criteria:

Report all newborn care provided from birth to discharge home, including care occurring after transfer from one hospital to another. Diagnosis codes for neonatal care:

DRG: 385-391 or WMA DRG codes 601-680.

ICD-9-CM: V30.x-V39.x, excluding stillbirths.

UB-92 revenue codes: 170-174, and 179.

Numerator #3, Surgery.

Clinical criteria:

Report all surgical stays with the following codes:

DRG: 1-8, 36-42, 49-63, 75-77, 103-108, 110-120, 146-171, 191-201, 209-234, 357-**370**, 285-293, 302-315, 334-345, 353-365, 392-394, 400-402, 496-**508**, 415, 439-443, 458, 459, 461, 468, 471, 472, 476-486, 491, 493, 494.

Or;

ICD-9-CM surgical codes with UB-92 revenue code 36X where "X" represents any third digit.

Numerator #4, Medical care.

Clinical criteria:

Report all inpatient medical stays with the following codes:

DRG: 9-35, 43-48, 64-74, 78-102, 121-145, 172-190, 202-208, 235-256, 271-284, 294-301, 316-333, 346-352, 366-369, 395-399, 403-405, 409-414, 416-423, 444-457, 460, 462-467, 473, 475, 487, 489, 490, 492.

Or;

ICD-9-CM diagnosis codes excluding codes for maternity, psychiatry, substance abuse, surgery, or other.

Numerator #5, Psychiatry.

Report all inpatient psychiatric stays with the following codes:

DRG: 424-432

Or;

WI MA DRG: 701-878;

Or;

ICD-9-CM: 290.0-290.9, 293-302.9, and 306-316.

UB-92 revenue codes: 114, 124, 134, 144, 154.

Numerator #6, Substance abuse.

Report all inpatient substance abuse stays with the following codes:

DRG: 433-437

Or;

ICD-9-CM: 291-292.9, 303.00-305.93.

UB-92 revenue codes: 116, 126, 136, 146, 156.

Numerator #7, Other (hospice, rehabilitation, respite) inpatient care.

Report all other inpatient stays including both hospital and non-hospital place of service codes with the following UB-92 revenue codes:

Hospice: 115, 125, 135, 145, 155, 650, 659;

Rehabilitation: 118, 128, 138, 148, 158;

Respite: 655.